DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH & THEIR FAMILIES
DIVISION OF CHILD MENTAL HEALTH SERVICES INTAKE SERVICES
1825 Faulkland Road Wilmington, DE 19805 (302) 633-2571 or (302) 633-2591

Please fill out this form as completely as possible and call if you need assistance.

Fax this form to (302) 633-2614

Date:	Client Name:		DOB:	
Gender: ☐M ☐F			Race:	Ethnicity:
Child's Current Address:				
City/Town:	County:	State:	Zip:	
Education Classification:	School:		Grade:	
With whom does child live?	Relation to child:			

Mother Name :_____ Address:_____
City: _____State: ____Zip_____ Employer:_____
Phone: (H)_____ (W)_____
Father Name:_____ Address:_____
City:_____ State: ____Zip_____ Employment:_____
Phone: (H)_____ (W)_____
Custodian Name:_____ Address:_____
City:_____ State: ____Zip_____ Employment:_____
Phone: (H)_____ (W)_____
Private Insurance ?:☐Y ☐N Name of company: _____
Is insurance exhausted? ☐ Yes ☐ No ☐Unknown
If insurance was denied, was it appealed? ☐ Yes ☐ No ☐ Unknown
If you have copies of letters from the insurance company or appeal, please attach.
Current MEDICAID?:☐Y☐N ☐Unknown
Court Involvement: Charges pending? : ☐Y ☐N Please attach available court orders.

When legible recent treatment records and assessments are attached, "see attached " is an acceptable response to questions below.

Most Recent Previous Treatment history:

Mental Health or Substance Abuse Treatment Provider:	Outpatient, day, residential, or hospital?	Admit Date	Discharge date

Current Therapist, Agency, number of sessions in last month

What child mental health or substance abuse problems do you want treated ?

1.

2.

3.

4.

Has the child threatened to hurt him/her self or actually injured him/her self? Has the child put him/her self in danger? Is there a family history of self-harm?

Describe past and present aggressive or violent behavior in the school, at home, and/or in the community:

Describe any use of drugs or alcohol by child and family.

Has the child been physically or sexually abused?

Has the child been involved in or witnessed serious violence or life threatening situations?

List all serious medical problems and significant disabilities.

Who is the child's family doctor? Phone if known:
List other doctors the child sees regularly and reason:

Current medicine	dose	Doctor who prescribed

What challenges has the family faced?

What are the child and family's strengths and interests?

If known, Most Recent Diagnosis: By Whom: Date:

Axis I:

Axis II:

Axis III:

Print Name of Applicant _____ Phone_____
Relationship to Child_____
Organization/Agency_____ Position _____
Signature _____
Parent/Guardian Signature (required) _____

If parent is not the applicant, include a consent for release of information signed by parent/custodian so that we know that the family supports the application.

 Client Name: _____ DOB: _____

DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES
Delaware Youth and Family Center

CONSENT FOR THE RELEASE OF CONFIDENTIAL ALCOHOL OR DRUG TREATMENT INFORMATION

I, _____, authorize
(Print name of youth)

Please check appropriate box:

- ☐ Division of Family Services (DFS)
- ☐ Division of Youth Rehabilitation (YRS)
- ☐ Parent / Guardian
- ☐ Family Court
- ☐ Superior Court
- ☐ Department of Education (DOE)
- ☐ Multi Disciplinary Team (MDT)
- ☐ Deputy Attorney General's Office (DAG)
- ☐ Public Defender (PD) / Private Attorney (PA)
- ☐ Other (Please specify): _____

☐ To disclose ☐ To receive from the Division of Child Mental Health Services the following information:

All information pertinent to substance abuse, including verbal communication, treatment progress and assessment, drug screen reports, and discharge summary.

The purpose of the disclosure authorized herein is to: Assist in completion of Child Mental Health evaluation(s), treatment recommendations, and / or placement.

I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I have the right to receive a copy of this form after completing it. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event, this consent expires automatically as follows:

THIS AUTHORIZATION WILL EXPIRE SIX (6) MONTHS FROM DATE OF SIGNATURE

_____	_____	_____
Signature of Youth (mandatory for 14 y.o. and older)	Print Name of Youth	Date
_____	_____	_____
Signature of Parent or Guardian (mandatory if client under 14 y.o.)	Print Name of Parent or Guardian	Date

PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING CLIENT IN ALCOHOL OR DRUG ABUSE TREATMENT

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with consent of such a client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION
DIVISION OF CHILD MENTAL HEALTH SERVICES

Please send to the County in which client permanently resides

KENT
821 Silver Lake Blvd, Suite 102
Dover, De 19903
Phone: (302) 739-4194
Fax: (302) 739-5701

NEW CASTLE
1825 Faulkland Road
Wilmington, DE 19805
Phone: (302) 633-2579
Fax: (302) 633-5116

SUSSEX
11-13 North Church St.
Milford, DE 19963
Phone (302) 422-1425
Fax: (302) 424-2960

Client Name:_____ DOB:_____

I _____ hereby authorize Child Mental Health Services (CMHS)

☐ To Release Verbal / Written Information to: ☐ To Obtain Verbal / Written Information from:

AGENCY NAME:_____
ADDRESS:_____
_____

The type of information to be disclosed is:

☐ Admission / Discharge Summary
☐ Psychosocial Evaluations
☐ Psychological Evaluations
☐ Psychiatric Evaluations
☐ Speech / Language Evaluations
☐ Progress Summaries
☐ Medication History
☐ MRI / Neurology Evaluations
☐ X-Ray Reports
☐ Other: _____

The purpose of this information disclosure is to assist in completion of Child Mental Health evaluation(s), treatment recommendations, and /or placement.

This authorization is valid until: _____Six months from the date of signature.
_____The following event or date, not to exceed one (1) year.

This consent may be revoked at any time, except to the extent that action has been taken in reliance on it. The person completing this form has a right to receive a copy. This form is invalid unless all sections are completed. Do not sign this form unless a specific request has been made and the request is in your child's best interest.

_____ _____
Client Signature (If applicable) Date Print Name

_____ _____
Parent, Guardian, Custodian Signature (Circle one) Date Print Name

This information has been disclosed from records whose confidentiality is protected by federal and state law. Any further disclosure is prohibited without the specific written consent of the person to whom it pertains, or as otherwise permitted by federal or state regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

STATE OF DELAWARE
EARLY AND PERIODIC SCREENING, DIAGNOSIS, TREATMENT (EPSDT)
MENTAL HEALTH AND SUBSTANCE ABUSE SCREEN

Child's Name _____ DOB _____

Date of Screen _____ Name of Screener _____

Title _____ Agency _____

Source of Information _____ Relationship to Child_____

The purpose of this screen is to identify children who may be in need of help with behavioral or emotional problems and/or who have risk factors associated with the development of behavioral or emotional problems. Not all children identified through this screen may require ongoing mental health treatment, however, if a child is identified, a referral for a more in-depth assessment may be made.

PART I

1. Is this screen being performed as part of the standard health screen (without specific problems being articulated?)

   YES NO

   If yes, skip to PART II.
   If no, complete numbers 2 - 3 below before completing PART II.

2. Is this screen being performed because there is a mental health emergency? (Immediate danger to self/others due to suicidal/homicidal threats/gestures/attempts in response to mental illness or emotional disturbance)

   YES NO

   If yes, what is the emergency?

3. Is this screen being performed in response to someone in the child's environment who has expressed concern about her/his current mental health adjustment or because substance abuse is suspected?

   YES NO

   If yes, who expressed concern? _____
   Relationship to the Child_____

   What is the concern?

 Client Name: _____ DOB: _____

PART II - DIRECTIONS

Screener should consider a child's age, developmental and intellectual level and overall functioning in identifying problems. Check the 2nd column if the problem has been observed within the last month. Check the 3rd column if the problem has ever been observed. Both columns can be checked or left blank.

CHILD'S PROBLEMS	In last month	Ever
1. Excessive irritability		
2. Overly sensitive to environment (noise, touch) which causes distress		
3. Excessive sadness, crying, withdrawal		
4. Excessive fears or worries, difficulty separating from parents, school refusal		
5. Recurrent intrusive thoughts or senseless repetitive behaviors, such as hand washing, lock checking, organizing objects		
6. Suicidal thoughts, threats, gestures or attempts		
7. Hallucinations (sees or hears things that aren't there), delusions (has strong beliefs which have no basis in reality)		
8. Difficulty in concentration		
9. Irregular or problematic sleep patterns		
10. Many nightmares		
11. Irregular or problematic eating/appetite patterns		
12. Problems in activity patterns (over-active or under-active)		
13. Injures self, e.g., cutting, head-banging		
14. Enuresis or Encopresis (wetting or soiling)		
15. Inability to give or receive appropriate affection to primary caregivers		
16. Inability to accept appropriate limits		
17. Easily angered or excessive anger or other strong emotion.		
18. Frequent, intense, uncontrollable temper tantrums		
19. Verbally threatening		
20. Physically violent		
21. Cruel to animals		
22. Willful destruction of property		
23. Fire setting		
24. Sexually preoccupied or inappropriate sexual activity		
25. Running away		
26. Suspected or confirmed abuse of alcohol or other drugs/substances		
27. Adolescent's pregnancy is/was related to behavioral/emotional difficulties		
28. Parenting (Youth is having trouble parenting his/her child(ren)		
29. Medical condition complicated by emotional disturbance or medical noncompliance		
30. Persistent unrealistic worry over physical health		
31. Problems in school/vocational activity (attendance, behavior, learning, performance)		
32. Suspected or confirmed victim of physical, sexual or emotional abuse		
33. Problems in interpersonal relationships (family and/or authority figures)		
34. Problems in interpersonal relationships (same age peers)		
35. Confirmed or suspected developmental delay		
36. Arrested, detained, or on probation		
37. Homicidal		
38. Gambling		
39. Avoids people, places or things		
40. Always seems jumpy or afraid		
41. Gets upset when remembering bad thing that have happened to him/her.		

PROBLEMS IN CHILD'S ENVIRONMENT	Within last month	Ever
1. Substance abuse and/or mental illness of biological parent(s)		
2. Substance abuse and/or mental illness of current caretaker(s) (if not living with biological parents)		
3. Substance abuse or mental illness of current household member (other than parent)		
4. Incarceration or arrest record of biological parent(s)		
5. Incarceration or arrest record of current caretaker (if not living with parents)		
6. Domestic violence		
7. Instability of residential arrangement, e.g., homelessness, multiple placements		
8. Psychosocial stressors, e.g., death, absence or loss of significant person in child's life and/or multiple life changes, serious illness in family, economic problems		
9. Inadequate or inappropriate parental supervision and/or discipline		
10. Suspected or confirmed victim of caregiver neglect, e.g. failure to provide food, shelter or clothing.		
11. Child has experienced traumatic event, e.g. flood, hurricane; frightening medical procedure; being or seeing someone severely injured (accident or assault); seeing a dead body or someone killed. Please explain _____ _____		

Submission of this form <u>does not</u> constitute a formal abuse report. As a mandated reporter, a screener is legally obligated to report suspected child abuse or neglect to DFS. (1-800-292-9582)

Any other problems not mentioned on this screen

<u>PART III</u> **Check one of the following:**

A. _____ Child NOW has at least one of the problems listed in Part II but is currently receiving services to deal with them.

B. _____ Child NOW has at least one of the problems listed in Part II and is not receiving services to deal with them.

C. _____ Child does not NOW have any of the problems listed in Part II according to the screener.

<u>PART IV</u> **Check one of the following:**

A. _____ Child has IN THE PAST had at least one of the problems listed in Part II and has received services to deal with them.

B. _____ Child has IN THE PAST had at least one of the problems listed in Part II but has never received services to deal with them.

C. _____ IN THE PAST , child has not had any of the problems listed in Part II according to the screener.

NOTE: The screener should make a referral to outpatient services if there is a check anywhere on this screen and the client has not received treatment to fully address the issue.

Screener Signature _____ Date _____

Agency/Position _____ Telephone _____

Parent/Legal Guardian Signature_____ Date _____

Revised 7/01/2006